

SPECIAL DIETARY NEEDS



CHAPTER 18

SPECIAL DIETARY NEEDS

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Special Dietary Needs

This chapter discusses the Child Nutrition Programs (CNP) federal guidelines when working with students that either require or request a special meal/diet in the USDA reimbursable program.

Idaho State Department of Education, Child Nutrition Programs (CNP) has a new website section called Special Dietary Needs Information. To find these sections go either directly to:

<http://www.sde.idaho.gov/child/cnp-dietary.asp> or <http://www.sde.idaho.gov/child/> and click the “CNP Resources” tab and then “Special Dietary Needs”.

This website features the following tools:

- “Helping the Student with Diabetes Succeed, A Guide for School Personnel” (partnership with U.S. Department of Health and Human Services)
 - ACCOMMODATING Children with Special Dietary Need (USDA Resource)
 - Medical Statement to Request Special Meals*
 - ❑ Blank form
 - ❑ Instructions on how to complete the form
 - ❑ Sample form completed by a doctor
 - ❑ Sample form completed by a RN
- *NOTE: The medical authority statement must identify: (1) The medical or other special dietary condition which restricts the child’s diet; (2) Food or foods to be omitted from the child’s diet; and (3) Food or choice of foods to be substituted.
- Food Allergy vs. Food Intolerance Definition
 - Guidelines for Managing Food Allergies in TN Schools
 - Presentation (Special Dietary Needs Power Point)
 - List of Condition and Symptoms

Meal Substitutions for Medical or Other Special Dietary Reasons

- Sponsors are required to offer meals to participants with disabilities whenever program meals are offered to the general population. Sponsors should be aware that the Individuals with Disabilities Education Act (IDEA) imposes requirements on states that may affect them, including the service of meals even when such service is not required by the Child Nutrition Programs. More information about IDEA can be found in the “Accommodating Children with Special Dietary Need” listed above.

- The provisions requiring substitutions for disabled participants states, “that no otherwise qualified disabled individuals shall, solely on the basis of a disability, be excluded from participation in, be denied benefit of or subjected to discrimination under any program or activity receiving federal financial assistance”.

The 504 Rehabilitation Act

The 504 is the *Rehabilitation Act of 1973* and the *Americans with Disabilities Act* (ADA) of 1990. The Act states, a "person with a disability" means any person who has a physical or mental impairment which substantially limits one or more major life activities, has a record of such impairment, or is regarded as having such an impairment.

Physician Statement Requirements

If a child has a disability, as defined by Section 504 of the Rehabilitation Act, CNP regulations **require** substitutions or modifications in school meals for children whose disabilities restrict their diets. A child with a disability must be provided substitutions when a statement signed by a licensed physician supports that need. The physician's statement must:

- Identify the child's disability
- Explain why the disability restricts the child's diet
- Identify the major life activity affected by the disability
- List the food or foods to be omitted from the child's diet
- List the food or choice of foods that must be substituted.

The Medical Statement form is available in the back of this chapter. Directions on how to fill it out are included along with two examples. Copies of this form can be downloaded from our website.

Food Allergies

Generally, children with food allergies or intolerances do not have a disability as defined under either Section 504 of the Rehabilitation Act or Part B of IDEA, and the school food service may, but is not required to, make food substitutions for them. However, when in the licensed physician's assessment, food allergies may result in severe, life-threatening (anaphylactic) reactions, the child's condition would meet the definition of "disability," and the substitutions prescribed by the licensed physician must be made.

Other Special Dietary Needs

Sponsors may make food substitutions at their discretion for individual children who do not have a disability, but who are medically certified as having a special medical or dietary need. Such determinations are only made on a case-by-case basis and must be supported by a statement which specifies the needed food substitutions and is signed by a licensed medical authority:

- Physician
- Physician Assistant
- Nurse Practitioner
- Registered Dietitian
- Registered Nurse

NOTE: This provision covers those children who have food intolerances or allergies but do not have life-threatening reactions (anaphylactic reactions) when exposed to the food(s) to which they are allergic.

People to Involve in Meeting Special Dietary Needs

When implementing these guidelines, foodservice personnel should work closely with the parent(s), responsible family member(s), or caregiver and with all other school, child care, medical and community personnel who are responsible for the health, well-being and education of participants with disabilities or with other special dietary needs to ensure that reasonable accommodations are made to allow such individuals' participation in the meal service.

For USDA Regulations on this specific topic, refer to 7 CFR Part 15b.3

Questions & Answers

- (1) Does the definition of disabled person include children with allergies, food intolerances and obese children?

ANSWER:

We interpret the definition of disabled person to mean that children are generally not considered disabled unless the child's disability substantially limits one or more major life activities. It is up to the child or his/her parent or guardian to request the special meals and to provide medical certification, from a recognized medical authority.

- (2) Where can a foodservice manager in a school or institution participating in the Child Nutrition Programs obtain assistance in complying with physicians orders?

ANSWER:

In Idaho, the Child Nutrition Coordinators in the State Agency will be able to help.

- (3) After the special meal has been provided, who is responsible for assisting with feeding if the child cannot feed him/herself?

ANSWER:

Assistance with feeding is the school's responsibility. It is not the responsibility of the foodservice manager. Many schools and institutions will already have aides available to provide the service as part of the child's total care plan.

- (4) If a disabled child's meal requires special preparation, equipment or feeding utensils, who is responsible for the purchase of such equipment?

ANSWER:

Section 504 specifies that program administrators must serve special meals **at no extra charge** to disabled students whose disability restricts their diet. Furthermore, there is no provision for additional federal reimbursement for the added expense. However, these costs are legitimate program costs that can be paid for out of the general foodservice funds that include regular federal reimbursement. If the administering agency is unable to absorb the costs, program administrators should investigate funding sources at the state and local agency level, such as vocational rehabilitation agencies.

Resources

American Academy of Allergy,
Asthma, and Immunology
1-800-822-2762
www.aaaai.org

American Academy of Pediatrics
1-847-434-4000 (National Headquarters)
www.aap.org

American Cancer Society
1-800-ACS-2345
www.cancer.org

American Diabetes Association
1-800-DIABETES
www.diabetes.org

American Heart Association
1-800-AHA-USA1
www.americanheart.org

Arthritis Foundation
1-800-283-7800
www.arthritis.org

Association for Retarded Citizens
(The ARC)
National Headquarters
301-565-3842
www.thearc.org

Autism Society of America
1-800-3-AUTISM
www.autism-society.org

Crohn's and Colitis Foundation
of America, Inc.
1-800-343-3637
www.ccfa.org

Cleft Palate Foundation
1-800-24-CLEFT
www.cleft.com

Easter Seals
312-726-6200 (voice)
312-726-4258 (TTY)
www.easter-seals.org

Epilepsy Foundation of America
1-800-EFA-1000
www.efa.org

Food Allergy & Anaphylaxis Network, Inc.
1-800-929-4040
www.foodallergy.org

Muscular Dystrophy Association of America
1-800-572-1717
www.mdaua.org

National Cystic Fibrosis Foundation
1-800-FIGHT CF
www.cff.org

Spina Bifida Association
of America
1-800-621-3141
www.sbaa.org

United Cerebral Palsy Association
1-800-USA5-UCP
(TTY) 202-973-7197
www.ucpa.org

MEDICAL STATEMENT TO

Request special meals AND/OR Accommodations

(1) Name of Participant	(2) Age or DOB	(3) Sponsor	(4) Site
(5) Name of Parent , Guardian, or Auth. Rep.	(6) Telephone (Parent , Guardian, or Auth. Rep.) ()	(7) Site Telephone Number ()	
<p>(8) Must check one:</p> <p><input type="checkbox"/> Participant is disabled or has a medical condition and <i>requires</i> a special meal or accommodation. (Refer to definition on reverse side of this form.) Sponsors must comply with requests for special meals and any adaptive equipment. A licensed physician must sign this form.</p> <p><input type="checkbox"/> Participant is not disabled, but is <i>requesting</i> a special meal or accommodation. An example may include a food intolerance. However, food preferences are not included as an example. Sponsors are encouraged to accommodate reasonable requests. A licensed physician, physician's assistant, registered dietitian or registered nurse must sign this form.</p>			

(9) Disability or medical condition requiring a special meal or accommodation: _____

(10) If participant is disabled, provide a brief description of participant's major life activity affected by disability:

(11) Diet prescription and/or accommodation: (Please describe in detail to ensure proper implementation.) _____

(12) Indicate texture: ☐ Regular ☐ Chopped ☐ Ground ☐ Pureed

Foods to be omitted and substitutions: Please list specific foods to be omitted and suggest substitutions. You may use the back of this form or attach a sheet with additional information.

(13) Foods to be omitted

(14) Suggested substitutions

_____	_____
_____	_____
_____	_____
_____	_____

(15) Adaptive Equipment: _____

(16) Signature of Preparer*	(17) Printed Name	(18) Telephone ()	(19) Date
(20) Signature of Medical Authority*	(21) Printed Name	(22) Telephone ()	(23) Date
(24) Signature of Parent/Guardian	(25) Printed Name	(26) Telephone ()	(27) Date

**Physician's signature is required for participants with a disability. For non-disabled participants, a licensed physician, physician's assistant, or registered nurse must sign the form.*

*The information on this form should be updated yearly to reflect the current medical and/or nutritional needs of the participant.
The USDA is an equal opportunity providers and employers.*

INSTRUCTIONS

- 1) Name of participant
- 2) Age of participant . For infants, please use DOB (Date of Birth).
- 3) Sponsor
- 4) Site: Site where meal will be served (e.g., school site, child care center, community center, etc.)
- 5) Name of Parent, Guardian, or Authorized Representative
- 6) Telephone: Telephone number of guardian, parent, or authorized representative.
- 7) Site Telephone: Telephone number of site where meal will be served. See #4.
- 8) Check: Check whether participant is disabled or not disabled.
- 9) Disability or Medical Condition Requiring a Special Meal: Describe medical condition that requires a special meal or accommodation. (E.g., juvenile diabetes, allergy to peanuts).
- 10) If Participant is Disabled, Provide a Brief Description of Participant's Major Life Activity Affected by Disability: Describe how physical condition affects disability. For example: "Allergy to peanuts causes anaphylactic shock which causes trouble breathing, choking, and potential death unless epinephrine injection is given immediately to the child and the child is sent to the emergency room for follow-up treatment."
- 11) Diet Prescription and/or Accommodation: Describe specific diet or accommodation that has been prescribed by a physician or describe diet modification requested for a non-disabling condition. For example, "All foods must be either in liquid or pureed form. Child cannot consume any solid foods."
- 12) Indicate Texture: Check the type of texture of food that is required. If the participant does not need any modification check "regular."
- 13) Foods to be Omitted: List specific foods that must be omitted. For example, "exclusion of fluid milk."
- 14) Suggested Substitutions: List specific foods to include in the diet. For example, "lactose reduced milk, calcium fortified juice."
- 15) Adaptive Equipment: Describe specific equipment required to feed the participant. (Examples may include tippy cup, large handled spoon, wheel-chair accessible furniture, etc.)
- 16) Signature of Preparer: Signature of person completing form.
- 17) Printed Name: Print name of person completing form.
- 18) Telephone: List telephone number of person completing form.
- 19) Date
- 20) Signature of medical authority: Signature of medical authority requesting the special meal or accommodation.
- 21) Printed Name: Print name of medical authority.
- 22) Telephone: Telephone number of medical authority.
- 23) Date
- 24) Signature of parent/guardian
- 25) Printed Name: Print name of parent/guardian.
- 26) Telephone: Telephone number of parent/guardian.
- 27) Date

Definitions

"Disabled person" is defined as any person who has a physical or mental impairment which substantially limits one or more major life activities, has a record of such an impairment, or is regarded as having such an impairment.

"Physical or mental impairment" means (1) any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological; musculoskeletal; special sense organs; respiratory (including speech) organs; cardiovascular; reproductive; digestive; genitourinary; hemic and lymphatic; skin; and endocrine; or (2) any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities.

"Major life activities" are functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning and working. "Has a record of such an impairment" is defined as having a history of, or has been misclassified as having a mental or physical impairment that substantially limits one or more major life activities.

MEDICAL STATEMENT TO

Request special meals AND/OR Accommodations

(1) Name of Participant Rosey Apple	(2) Age or DOB 10/0/96=4 yrs	(3) Sponsor Riverglen Day Care	(4) Site Oakmont Street
(5) Name of Parent , Guardian, or Auth. Rep. Myra Apple	(6) Telephone (Parent , Guardian, or Auth. Rep.) (707) 555-4321	(7) Site Telephone Number (707) 555-0692	
<p>(8) Must check one:</p> <p><input type="checkbox"/> Participant is disabled or has a medical condition and <i>requires</i> a special meal or accommodation. (Refer to definition on reverse side of this form.) Sponsors must comply with requests for special meals and any adaptive equipment. A licensed physician must sign this form.</p> <p><input type="checkbox"/> Participant is not disabled, but is <i>requesting</i> a special meal or accommodation. An example may include a food intolerance. However, food preferences are not included as an example. Sponsors are encouraged to accommodate reasonable requests. A licensed physician, physician's assistant, registered dietitian or registered nurse must sign this form.</p>			

(9) Disability or medical condition requiring a special meal or accommodation: **Rosey is allergic to soybeans.**

(10) If participant is disabled, provide a brief description of participant's major life activity affected by disability:

This disability is a life-threatening condition. Consuming soybeans can cause Rosey to go into Shock requiring an injection of epinephrine and immediate medical attention.

(11) Diet prescription and/or accommodation: (Please describe in detail to ensure proper implementation.)

Exclusion of all soybeans and soybean products

(12) Indicate texture: ☐ Regular ☐ Chopped ☐ Ground ☐ Pureed

Foods to be omitted and substitutions: Please list specific foods to be omitted and suggest substitutions. You may use the back of this form or attach a sheet with additional information.

(13) Foods to be omitted

Alernate Protein Products (such as TVP, VPP)

Soy milk, soy flour

Soy oil, soy sauce or soy flour

(14) Suggested substitutions

Hamburger, ground turkey or beef, chicken

Cow's milk White or whole wheat flour

Peanut, corn, or safflower oils

(15) Adaptive Equipment: _____

(16) Signature of Preparer*	(17) Printed Name	(18) Telephone ()	(19) Date
(20) Signature of Medical Authority* Robert Cisneros, MD	(21) Printed Name Robert Cisneros	(22) Telephone (313) 555-2222	(23) Date 10/15/02
(24) Signature of Parent/Guardian Myra Apple	(25) Printed Name Myra Apple	(26) Telephone (313) 555-4321	(27) Date 10/15/02

*Physician's signature is required for participants with a disability. For non-disabled participants, a licensed physician, physician's assistant, or registered nurse must sign the form.

The information on this form should be updated yearly to reflect the current medical and/or nutritional needs of the participant.
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MEDICAL STATEMENT TO

Request special meals AND/OR Accommodations

(1) Name of Participant Kenda Tung	(2) Age or DOB 16 years	(3) Sponsor Harte School District	(4) Site Hartnell School
(5) Name of Parent , Guardian, or Auth. Rep. Leona Tung	(6) Telephone (Parent , Guardian, or Auth. Rep.) (854) 555-3211	(7) Site Telephone Number (854) 555-0112	
<p>(8) Must check one:</p> <p><input type="checkbox"/> Participant is disabled or has a medical condition and <i>requires</i> a special meal or accommodation. (Refer to definition on reverse side of this form.) Sponsors must comply with requests for special meals and any adaptive equipment. A licensed physician must sign this form.</p> <p><input type="checkbox"/> Participant is not disabled, but is <i>requesting</i> a special meal or accommodation. An example may include a food intolerance. However, food preferences are not included as an example. Sponsors are encouraged to accommodate reasonable requests. A licensed physician, physician's assistant, registered dietitian or registered nurse must sign this form.</p>			

(9) Disability or medical condition requiring a special meal or accommodation: **Lactose intolerance**

(10) If participant is disabled, provide a brief description of participant's major life activity affected by disability:

(11) Diet prescription and/or accommodation: (Please describe in detail to ensure proper implementation.)

Exclusion of fluid milk

(12) Indicate texture: ☐ Regular ☐ Chopped ☐ Ground ☐ Pureed

Foods to be omitted and substitutions: Please list specific foods to be omitted and suggest substitutions. You may use the back of this form or attach a sheet with additional information.

(13) Foods to be omitted

(14) Suggested substitutions

Milk

Lactose-free milk, calcium-fortified juice
fruited yogurt

(15) Adaptive Equipment: _____

(16) Signature of Preparer* Jennifer Stein, RD	(17) Printed Name Jennifer Stein, RD	(18) Telephone (707) 555-0897	(19) Date 10/01/02
(20) Signature of Medical Authority* Lynda Philess, RD	(21) Printed Name Lynda Philess, RD	(22) Telephone (707) 555-1661	(23) Date 10/01/02
(24) Signature of Parent/Guardian Leona Tung	(25) Printed Name Leona Tung	(26) Telephone (854) 555-3211	(27) Date 10/01/02

*Physician's signature is required for participants with a disability. For non-disabled participants, a licensed physician, physician's assistant, or registered nurse must sign the form.

The information on this form should be updated yearly to reflect the current medical and/or nutritional needs of the participant.
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